

A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care

A New Physician Payment and Delivery Model An Issue Brief

The American College of Physicians (ACP), which represents more than 120,000 internal medicine physicians (internists) and medical students, proposes a new physician payment and delivery model that builds upon and extends existing ACP policy to address the core deficiencies of the current payment and delivery system. In a new policy paper released in January, 2007, ACP proposes to restructure conventional fee-for-service payment policies by:

- Instituting a multi-component, bundled payment structure that facilitates more effective and efficient care delivery for patients through the Advanced Medical Home (AMH). The AMH, also called the patient-centered medical home in joint principles adopted by the American Academy of Family Physicians and the ACP, offers the benefits of a personal physician with a whole-person orientation who accepts overall responsibility for the care of the patient and leads a team that provides enhanced access to care, improved coordinated and integrated care, and increased efforts to ensure safety and quality.
- Eliminating Medicare's Sustainable Growth Rate (SGR) formula for annual physician fee updates. The College proposes a transitional pathway to accomplish this goal that culminates in a stable and predictable methodology for updating physician payments and creates positive incentives for physicians to participate in quality improvement programs.

At the end of the transition, the SGR would be replaced with a new update system that would establish a baseline physician payment update that takes into account the costs of delivering care, beneficiary access to services, workforce and other data on trends that may affect access and quality; provide ongoing funding for programs that can achieve quality improvements and cost efficiencies, and allow for targeted changes in payment policies to achieve specific policy objectives.

- Implementing changes within the Resource Based Relative Value Scale (RBRVS) system that improve the accuracy of work and practice expense relative values, providing incentives for the adoption of health information technology linked to quality improvement efforts, as well as for physicians to continuously improve, measure and report on the quality and cost of the care provided.

Specific Recommendations

The College offers the following specific recommendations to address inadequacies in the current Medicare physician payment and delivery system and to promote more patient-centered, longitudinal, coordinated care:

1. The College recommends that Medicare and other healthcare payers implement changes to support a new model of service delivery with related risk-adjusted prospective payments for ambulatory care that uses systems that promote patient-centered, longitudinal, coordinated care. This new model would apply to physicians in practices that have demonstrated key attributes necessary to manage care consistent with this approach, and would take into account the increased work and resources associated with providing this model of care.

2. The College recommends that this new payment and delivery model be based on the principles of the Advanced Medical Home (AMH), which offers the benefits of a personal physician with a whole person orientation and provides enhanced access to care, coordinated and integrated care, and increased efforts to ensure safety and quality. This model would improve the care for all patients and address current unmet needs of the chronically ill.

3. The College recommends that a multi-component, bundled payment structure be implemented that results in a substantial increase in payments to primary and principal care physicians who accept responsibility for care management and coordination in recognized AMH practices. The payment structure should have a prospective component and be risk adjusted to reflect differences in the case mix of patients being treated. The increased reimbursement resulting from this payment structure must be sufficient to support the initial and sustained practice redesign and clinical work associated with effective management of patients in a variety of practice settings; particularly in smaller practices that provided the majority of care to Medicare beneficiaries. The payment model should specifically include a:

- **Prospective, bundled structural practice component that covers practice expenses linked to the delivery of services under the AMH model not covered by the current Medicare Resource Based Relative Value Scale (RBRVS) system.**
- **Prospective, bundled care coordination component to cover physician and non-physician clinical and administrative staff work linked to the delivery of services under the AMH model not covered by the Medicare RBRVS system.**
- **Visit-based fee component for services delivered as part of a face-to-face visit, which are already recognized by the Medicare RBRVS system.**
- **Performance-based component based on the achievement of defined quality and cost effectiveness goals as reflected on evidence based quality, cost of care and patient experience measures.**

4. The College recommends that Congress enact legislation to direct the Secretary of HHS to implement a large-scale Medicare pilot project of the AMH model. The pilot should include a bundled payment structure that supports practices, including smaller practices, recognized as AMHs; authority to institute incentives, such as reduced deductibles and co-insurance, for beneficiaries to select a physician within a recognized AMH as their personal physician; and non-financial incentives, such as reductions in documentation requirements, for practices that qualify as AMHs. The proposed pilot should also include representation from practices of varying sizes (with substantial representation from small practice settings), in different geographic settings and of varying levels of professional maturity. Upon completion of the pilot program, the Secretary should be authorized to implement changes in Medicare payment policies, including changes that will allow physicians in an AMH to share in program-wide savings attributable to them, to provide sustained and ongoing support to practices nationwide that meet the qualifications as an

AMH. (HR 6408, “The Tax Relief and Health Care Act of 2006,” which was signed into law by President Bush on December 20, includes a Medicare pilot of the AMH in eight states that will enable qualified physicians who are participating in the pilot to receive a “care coordination” fee and to share in program-wide savings associated with reductions in hospital rates. This pilot was based on legislative language that ACP provided to Congress. The College will work with CMS on assuring that this pilot follows the concepts recommended by ACP as closely as possible, while working with Congress on additional avenues for implementing, testing, evaluating, and demonstrating the value of a new payment structure to support the AMH model.)

5. The College recommends that the Centers for Medicare and Medicaid Services (CMS) provide separate Medicare payments under the RBRVS system for services that facilitate patient-centered, longitudinal, coordinated care to be used by physicians in practices that cannot provide all of the attributes necessary to qualify as an Advanced Medical Home in order to encourage improved and more efficient delivery of services.

6. The College recommends that CMS implement procedures within the RBRVS system that:

- Improve the accuracy of work and practice expense relative values;
- Provide an incentive for the adoption of health information technology linked to quality improvement efforts;
- Provide incentives for physicians to participate in programs to continuously improve, measure and report on the quality and cost of the care provided.

7. The College strongly supports the Medicare Payment Advisory Commission’s (MedPAC) recommendation to eliminate the flawed SGR formula and further recommends that it be replaced with a methodology that provides positive, stable and predictable updates to physician payments.

8. The College recommends that alternative volume or budget controls be considered by Congress only as a back-up mechanism and only to the extent that other reforms in payment methodologies to improve quality and introduce greater efficiency are found to be insufficient. These other reforms include aligning Medicare payments with quality improvement, promoting adoption of HIT in support of quality improvement, promoting physician-guided care management and the advanced medical home, encouraging evidence-based medicine, supporting the value of primary care, and addressing mispricing of services.

9. The College recommends that Congress establish a pathway toward eliminating the SGR and creating a more stable and predictable method for updating payments to physicians that would combine annual updates reflecting increases in practice expenses, performance based payments, and additional payment increases to achieve specific policy objectives. This pathway should include a specified legislative timeframe – no later than five years—for sunsetting the flawed SGR formula. Such legislation should establish a transition period that will result in positive, stable and predictable annual percentage updates to all physicians and increased payments for participating in a voluntary pay-for-reporting program.

At the end of this transition period, a new approach to establishing annual Medicare fee schedule payment updates to physicians should be established. This new approach should include the following components:

- A stable and positive baseline percentage update in the conversion factor for all services that takes into account the costs of delivering care, beneficiary access to services, workforce and other data on trends that may affect access and quality.
- An additional percentage amount, above Medicare baseline spending on physician services, to fund a physicians' quality improvement pool, which would provide funding for programs that have the potential to achieve better outcomes for patients and more efficient use of resources. This pool will provide a dedicated source of funding for physician-led programs that the Secretary has determined can achieve program-wide quality improvements and cost efficiencies, such as programs to address regional variations in quality and cost of care, programs to improve care of patients with chronic diseases, and surgical outcome and measurement programs. Funds dedicated to the pool would include shared savings from program-wide improvements rather than being limited to Part B funding.
- Additional optional targeted "add-ons" to payments for certain categories of services to achieve desired policy objectives, such as increasing the supply of primary care physicians.

Conclusion

The guiding philosophy of these recommendations is that patient needs are best met through the delivery of patient-centered, longitudinal, coordinated care. This is the model of care that primary care providers and other physicians who provide principal care are trained and well-suited to deliver yet has been historically unrecognized or under-recognized by the payment system. The College believes that these proposals will improve the quality and effectiveness of care provided in this country and facilitate a sustainable environment in which physicians are provided adequate incentives for furnishing care appropriate to the patient population.